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ABSTRACT

A stakeholder approach was used in the evaluation of the basic science courses of the University of North Dakota School of Medicine. The stakeholder approach attempted to structure the working relationship between the evaluator and the program stakeholders so that they participated in choosing issues, data to be collected, and ways to organize and present the data. The clients in this evaluation had a sense of input and control; changes accepted as policy directives were based on their recommendations. Growth in a planned direction resulted from this evaluation process. The model used, one of evaluation as an active process occurring in a political situation, is adaptable to many situations. Factors contributing to a successful stakeholder evaluation include: (1) identifying the decision makers; (2) defining the evaluation's nature, character, and purpose; (3) establishing congruence between the goals and objectives of the evaluator and the audience; (4) legitimizing different stakes in the program; and (5) providing information to the appropriate person in an acceptable format. (SLD)

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A Curriculum Evaluation Using the Stakeholder Approach as a Change Strategy

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Evaluations may serve multiple functions: clarifying goals and objectives, determining criteria for measuring success, identifying unintended outcomes, assessing the value of a program - but ultimately, the purpose of an evaluation is to provide information for making decisions. In the 1970s nonutilization of evaluation results became a major research concern as evaluators began to realize that evaluation results were not contributing to concrete decisions (Hueftle, 1984). There has been increasing recognition that even methodologically sound evaluation research is not used either by those being evaluated or by decision makers (Goldstein, Marcus, & Rarsch, 1978; O'Reilly, 1981). One evaluator summarized the problem with this lament: "With all the money, time, effort, skill, and iritation that went into the acquisition of information, why does it generally have so little impact?" (Weiss, 1972, p. 26). Consequently, a number of evaluators have suggested selecting evaluation protocols according to their potential for providing practical and useful results (Patton, 1982; Rossi & Freeman, 1982; Rovers, 1986).

Stakeholder, or responsive evaluation, evolved in the late 1970s at the National Institute of Education due to an increasing concern with the lack of utility of evaluation results (Weiss, 1983). It was hypothesized that attempts to rely on quantitative methods, to remain apolitical and to organize ~~evaluation~~ evaluations around issues that should exist result in obtaining inappropriate information. Data remains unused because it relates to questions which are not of primary concern to persons involved in the program and hence, evaluation results do not have an impact on program change. Basically, the stakeholder approach attempts to restructure the working relationship between the consultant and groups involved in the program, the stakeholders, in such a way that the stakeholders participate in deciding the issues that the evaluation will address, the kinds of data to be collected, and how it will be organized and presented.

At the University of North Dakota School of Medicine, the curriculum phases are evaluated on a rotating three year basis. Through the Office of Medical Education, I was asked to assist with the evaluation of Phase II, the basic sciences, and I utilized a stakeholder approach: Information would be provided only if there was intended usage and a decision making purpose, i.e., a felt need.

METHOD

Gold (1981) outlines the essential features of the stakeholder approach which include assessing initial program capability; identifying stakeholders and determining their expectations; matching stakeholder expectations with program capabilities; and timely, regular feedback to stakeholders of evaluative information as the program is implemented. The model does not

prescribe a strictly defined set of procedures; rather it suggests a cooperataive process in which the clients' interests are foremost. This client orientation influenced planning at each stage of the evaluation.

Determination of initial expectations began informally. I met with the administration, faculty, and students to gain a sense of their expectations for the evaluation, i.e., what did they want and need to know? Specific concerns were elicited. These ranged from very broad (Are students being prepared to begin clinical training?) to the very specific (How many hours did you study last night?). A working group which included representatives of the students and faculty, course directors, and two deans rated the potential questions and selected those to be addressed, thus limiting the scope of the evaluation. At meetings with this group. I described the stakeholder approach and asked about such requirements as deadlines, the best way to present the data, who should receive feedback, etc.

The proposed design emphasized obtaining descriptive data rather than prescribing any manipulation of the program. I suggested multiple methods for data-gathering so that the issues would be covered from various perspectives and provide a crosscheck on the information received. The working group elected to collect data through small group discussion, a checklist, and interviews. Finalizing the design was a cooperative process relying on the stakeholder group for input and problem-solving, e.g., would they accept the information derived from student interviews as valid? Would students have the time to participate with finals approaching? After discussion, several volunteers developed and piloted the checklist and interview questions. An acceptable design was defined as one whose components reflected program intents, objectives, and concerns of the audience. The design was not finalized and approved until it was acceptable to the entire group.

Stakeholders participated in collecting the information: Course directors met with their faculty in small groups to discuss issues and report their findings, and students were interviewed. In both cases, the likelihood of predetermined responses was minimized, that is, interviews were relatively unstructured, and new questions were added as relevant concerns became apparent. Thus, the overall design continuously evolved. There was no attempt to control the setting, instead the goal was understanding through direct personal contact and experience with the program. More than one source provided information on each topic, but there was a determined effort to answer the questions and not provide more information than was needed to address the issues.

Analysis of the data was organized around the stakeholders' concerns with an emphasis on collating themes or pictures from different sources. Both faculty and student perspectives were

related to each issue. Data included quantitative comments as applicable. Frequent informal dialogue and progress reports constituted early reporting. More formal documentation was organized around the stakeholders' questions; thus, students, individual faculty, the committee of representative stakeholders, and the administration required different information. Experiences were portrayed in these reports using the language of informants (for example, one topic was characterized as "Mickey Mouse"), and descriptive material was used to provide a feeling of what the program was like. After discussion, recommendations were generated and voted upon. These passed through the administrative committee structure and became part of school policy.

The stakeholder approach involved both a theoretical reorientation and a practical working strategy. It felt more active: I was not an impartial observer but a participant. It emphasized taking different perspectives and recognizing the complexity of the educational enterprise which has differing priorities, "stakes," at work in the process. Some frequent evaluation criticisms did not surface (Weiss, 1983). That is, it wasn't irrelevant because it related to expressed needs; unrealistic, because no predetermined standards were set; or unfair, because the needs of less powerful groups such as students and supporting faculty were considered.

Feedback from the first evaluation was generally positive, but I could only hope that the approach would be followed by actual change. As one of the faculty participants noted: "I liked the evaluation. It was very well done, but I have a problem with evaluations in general. I don't see anything changing. What good is the effort if it is impossible to make changes?" The succeeding evaluation three years later allowed me to determine the degree to which the evaluation had specifically addressed the problem of underutilization: Had the results influenced policy or program implementation?

RESULTS

Stakes (1975) defines the ultimate test of validity for an evaluation as an increase in the audience's understanding of the entity that was evaluated. A useful operational measure for this increase is a reduction in the number and level of concerns held by the audience and in the resolution of issues passed by them. Did this happen? Seven areas were targeted as needing improvement in the original evaluation. Briefly, they were: increasing clinical input, introducing community care needs, health care costs, and preventive medicine; practicing alternative forms of curriculum delivery; maximizing student self-learning;providing work-time estimates; concern with students' attitudes developing as a means of coping with pressure, i.e., becoming "less human"; and developing methods of assessing problem-solving skills. Six of the final recommendations were related to concerns which had been suggested

as issues for the evaluation by the administration and faculty. One, attitudes and coping with stress, was an issue raised by students. To ascertain whether decisions had been made and implemented in the three years, program descriptions were obtained as before. A random sample of students one quarter of the class stratified by grade point average was interviewed using identical questions by the same interviewer. Faculty met with their respective course directors and completed the same questionnaire. Only one course director changed during this time period and there were new faculty members. Questions which had arisen because of new concerns and/or requests for specific information were added on a separate sheet. Thus, althoughdata was being gathered to measure changes which had occured in response to the initial evaluation, the second evaluation incorporated new concerns so that it remained responsive to the current stakeholders.

Content Changes

The faculty indicate that clinical input increased dramatically. Of eight courses in the first year, the number of courses routinely presenting clinical correlations increased from one to four; using clinical speakers increased from four to six. New methods of presenting clinical material such as field trips to the Rehabilitation Hospital and Veterans Admnistration occurred in three classes. Two courses added additional textbooks to provide case studies and clinical correlations.

Community care needs had been introduced in one course, discussed in one and considered not applicable in six. Currently, these topics are introduced in four courses and discussed in two. Preventive medicine was added to three courses and a discussion of health care costs in one.

Students seconded the faculty's opinions: During the student interviews, clinical input was recognized. They noted new experiences, e.g., interviewing real or simulated patients and field trips. In other cases, the type of input was the same, but it increased from "only minimal, tidbits" to "good."

Instructional Delivery

Additional self-learning materials are available in the form of self-instructional packages (available in five instead of four courses), course handouts (eight instead of six), and computer-assisted instruction (available in two rather than one course). Instructors reported working on methods for student self-assessment. Students also noted an increase in the availability of learning aids in three classes and reported an increase in their use. For example, previously five Anatomy students of the thirteen interviewed were not sure if there were any out-of-class aids for self-learning. Audiovisuals were reportedly a low priority both in and out of class, and more handouts were requested. This year eleven of the thirteen students knew about

the availability of self-study aids, and nine actually used the videotapes. The number of learning aids increased from a reoprted zero in one course to four. All of the students were aware of the addition of a computer test bank.

The number of lecture hours was reduced by approximately 15%. A total of 1050 is allowed (35 weeks at 30 hours of contact per week) and approximately 900 are utilized. Faculty now report using only slightly more lectures than other types of instruction, 488 hours compared to 401 hours of non-lecture (lab, discussion groups, problem-based learning, review sessions, etc.).

Providing work-time estimates was a recommendation that did not substantively change or have any policy response. Although one more course reports having estimates, there is still confusion about what they are and how they should be used. However, in response to concerns about the workload, the administration initiated a stress program for freshman students in which they meet in small groups with sophomore facilitators to discuss concerns.

Six of the thirteen students initially interviewed had characterized the volume of work as overwhelming. Although most experienced no real problems, i.e., actual failure, they felt they were pushed to their limits. The change this year is striking: No one reported being overwhelmed. Seven stated that the year was "not that bad"; it "could be managed." Students expressed an awareness that their attitude could make a difference.

Developing methods of assessing problem-solving skills

All courses now formally assess clinical problem-solving whereas before one-fourth of the courses thought this was not applicable in the basic science years. Over half of the courses also report an increased effort to assess clinical problem-solving skills informally, e.g., in discussions and lab.

Other Changes

Six of the seven recommendations were addressed. What about other developments during this period? Perceived changes that did not specifically address the recommendations included 1) less excessive demands on faculty time, and 2) evaluation procedures which received better ratings in terms of being "fair." In ten other areas which were reassessed such as integration of courses, teaching packages, and remediation, no change was noted. Student-initiated issues including lecture quality, desire for more flexibility, and the availability of self-learning also revealed no consistent change or new trends.

Thus, the changes which occurred were based almost exclusively on program concerns and information described in the

first evaluation. Changes were validated independently by both faculty and students in both quantitataive (e.g., an overall increase in numbers) and qualitative (e.g., "Clinical Day was fantastsic") terms. Areas not targeted did not change. Faculty initiated all of the changes except one under the direction and control of the Dean's office (the stress program). The seven recommendations were approved by school committees, hence policy decisions were made. Implemlentation to varying degrees of six recommendations occurred.

DISCUSSION

What was the relationship of the evaluation to the changes that occurred; did the stakeholder approach make a difference? According to interviews with the Associate Dean and members of the administrative policy committees, the key factor was one of ownership. The clients had a real sense of input and control. They determined the focus, gathered data, discussed and formulated recommendations. Their recommendations then went through official channels and were accepted as policy directives.

Faculty members felt that the recommendations were implemented because the changes suggested were needed, group consensus existed; the recommendations were phrased as broad directives rather than specific mandates which would be rejected; they had a choice in how to implement the recommendations, e.g., clinical input for some meant having a clinician speak, for others, it meant using case histories.

However, extradepartmental evaluations were generally perceived as a necessary evil. Faculty noted that teaching is only one responsibility and that keeping up with new content is more important than how they are teaching. Most of the recommendations were perceived to be in the area of delivery and hence, had a low priority. It was admitted that changes in this area would be unlikely to occur without outside impetus.

The evaluation also stimulated changes through informal mechanisms, i.e., it promoted discussion. Discussion at the completion of an evaluation tends to center around the recommendations which generates controversy and new ideas. Sometimes group pressure builds for change in a particular area, for example, when the testing criteria in one course is not equivalent to grading in other courses. When there is no group consensus, the process of change may be slower, but at least dialogue has started. In Stake's terms, there was an increase in understanding as reflected by focusing on common concerns.

There are, of course, multiple factors involved in complex change. For example, having a new course director typically leads to reorganization and an opportunity to implement changes. It is naive to assume that no information discussion, or planning existed prior to the evaluation findings. Rather, evaluation results should be viewed as an additional source of information

which hopefully has an effect, if only in part, on decision-making. It is but one piece of information that flows into the slow, developing process of program development (Alkin, 1975). Also, ideas may already be incubating, but it may take an external impetus to begin action. As one faculty member noted, "It was time."

CONCLUSIONS

Too often, evaluations are not used. An examination of the evaluation literature finds very few instances where the findings of an evaluation were adopted and led to a set of concurrent program decisions (Alkin, 1975). Despite good design and data, they seem to have no effect upon decision-makers or program outcomes. Yet, the primary rationale for an evaluation is that it provides information for action and contributes to decision making. "In short, in an evaluation it is important if someone needs the evaluation and someone cares" (Alkin, 1975, p. 201).

There are universal characteristics of evaluation models, such as clarifying objectives and defining the role of the evaluator, which are applicable in any curriculum evaluation. However, selection of the features to be evaluated depends upon conceptualization of the philosophy and goals of the program. The stakeholder model, used in this evaluation, suggests that the information asked and data provided must be in response to concerns of people actively involved in the program if the evaluation is to have an impact. The presentation of data unrelated to actual concerns is unlikely to affect decision making. This approach proposes orienting directly to program activities rather than to program intents, responding to audience requirements for information, and allowing for different perspectives when reporting the results. In this case, issues discussed in the initial evaluation of Phase I led to the adoption of recommendations by the stakeholder groups. These recommendations became administrative policy and were returned to the group for implementation. Without further directives, changes evolved over the subsequent three years, changes apparent to both faculty and students. There were changes in all courses: changes in content, teaching, and evaluation. Overall, there seemed to be an orientation towards implementing the recommendations by fitting them into the existing course structure. The method of initiating change and the type of change varied, but the end result was growth in a planned direction.

Factors which contribute to a successful stakeholder evaluation are a) identifying the decision makers; b) defining the nature, character, and purpose of the evaluation; c) establishing congruence between the goals and objectives examined by the evaluator and those of interest to the audience; d) legitimizing different stakes in the program; and e) providing information as needed to the appropriate person in a format that will be acceptable. These activities are congruent with several

principles regarding successful implementation of change such as involvement of all who will be affected by the decisions to be made, a broad base of participation, and open lines of communication (Mauksch & Miller, 1981).

Potential problems in conducting a stakehlder evaluation include the amount of preliminary work which is required to determine initial expectations, conflicting issues between stakeholders who have no agenda or who do not want to know anything, or conversely, too many predetermined issues to be covered. The approach assumes that it is possible to be responsible and responsive to many issues even if this takes the form of recognizing the political nature of the evaluation process and legitimizing the diversity of interest. The process may be helped by involving representatives of all vested groups, limiting expectations, using multiple sources of information, ascertaining that the data will have validity for the clients, and engaging in frequent dialogue with those in and around the program.

The model used is one which is adaptable to many situations: Evaluation is perceived as an active process occurring in a political situation. There is no single truth to be uncovered, on the contrary, a developmental process is being observed. Each program affects many groups and their concerns are legitimate. Frequently there is no follow-up to evaluations to determine if prior recommendations have been implemented. Using a stakeholder approach with repeated measures enables evaluators to plot and progress toward attainment of goals as well as to monitor changes in concerns and issues.

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